



# FIRST STEPS PART C ELIGIBILITY DETERMINATION STATEMENT

State Form 50054 (R3 / 4-06) / BCD 0076

Division of Disability and Rehabilitative Services



Effective May 01, 2006

County	Date (month, day, year)
Name of person completing this form	Title
Name of child	Date of birth (month, day, year)
Family name	Date of referral (month, day, year)
Eligibility determination activities pursuant to Sections 303.300 and 303.322 of 34 C.F.R. Part 303 were conducted for this child and are recorded in Section 3 of the IFSP document and resulted in the findings as stated below.	
Service Coordinator initials	

## Confirmation Of Development Delay:

- ☐ 20% delay in two (2) or more developmental domains OR one and one-half (1.5) standard deviations below the mean  
(check methodology below)
- ☐ Administered STANDARDIZED Assessment(s) OR Criterion-referenced tool (As documented in Section 3 of the IFSP)
- ☐ Informed Clinical Opinion (provide a statement on page 2 utilizing at least 3 areas of Section 3 of the IFSP)  
If a standardized tool is not available or appropriate, a child may be determined to have a developmental delay by informed clinical opinion of a multidisciplinary team, including the parent and documentation from the child's primary health care provider.
- ☐ 25% delay in one (1) or more developmental domains OR two (2) standard deviations below the mean  
(check methodology below)
- ☐ Administered STANDARDIZED Assessment(s) OR Criterion-referenced tool (As documented in Section 3 of the IFSP)
- ☐ Informed Clinical Opinion (provide a statement on page 2 utilizing at least 3 areas of Section 3 of the IFSP)  
If a standardized tool is not available or appropriate, a child may be determined to have a developmental delay by informed clinical opinion of a multidisciplinary team, including the parent and documentation from the child's primary health care provider.

## High Probability of Developmental Delay (attach signed and dated physician statement)

- ☐ Chromosomal abnormalities or genetic disorder ☐ Neurological disorder ☐ Severe toxic exposure, including prenatal exposure
- ☐ Sensory impairments, including vision or hearing ☐ Congenital malformation ☐ Neurological abnormality in the newborn period
- ☐ Low birth weight  $\leq$  1500 grams

Primary	ICD-9 code
Secondary	ICD-9 code

- ☐ 1. As determined by the multidisciplinary team, the child is determined **NOT ELIGIBLE** due to: \_\_\_\_\_
- ☐ The parent agrees with the decision.
- ☐ The parent does NOT agree with the decision, and therefore has been informed of their rights and responsibilities.
- ☐ The parent continues to have questions/concerns relating to the team's decision, and therefore has been informed of their rights and responsibilities.
- ☐ 2. As determined by the multidisciplinary team, the child is determined **ELIGIBLE**.
- ☐ 3. Eligible, but not in need of services at this time.

**INFORMED CLINICAL OPINION**

This child is eligible based on informed clinical opinion. Eligibility is based on the parent / caregiver's report of developmental history, the review of pertinent records related to the child's health status / medical history (*as recorded in Section 3 of the IFSP*) and at least one (1) of the following assessment procedures documenting delayed development:

- ☐ Observational assessment or planned observation of a child's behaviors and parent / child interaction
- ☐ Non-standardized assessment
- ☐ Other: \_\_\_\_\_

Provide a statement of eligibility when using informed clinical opinion

**VERIFICATION OF RIGHTS**

*Check as appropriate*

- ☐ Yes ☐ No Conducted in family's native language / mode of communication
- ☐ Yes ☐ No Instruments were free from racial / cultural discrimination
- ☐ Yes ☐ No No single procedure was used to determine eligibility
- ☐ Yes ☐ No Instruments were administered by qualified personnel
- ☐ Yes ☐ No Assessment of child's needs completed
- ☐ Yes ☐ No Assessment of child's strengths completed

**CONFIRMATION OF ELIGIBILITY**

The following Multidisciplinary Team members agree that the child ( ☐ does ☐ does not ) meet Part C eligibility criteria:

DATE	NAME	POSITION	METHOD OF PARTICIPATION OR SIGNATURE
		Parent *	
		Parent *	
		Intake Coordinator	
		Service Coordinator	
		First Discipline	
		Second Discipline	
		Physician	

\* The parent(s) is a required member of the eligibility team.